Communiversity

Refugee Mental Health Project

Prepared in partnership with
University of Minnesota School of Social Work, the University of Minnesota Department of Family Social Science, the Center for Victims of Torture, and the Minnesota Department of Public Health Refugee Health Coordinator's Office

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Background

Refugees resettling in the United States have often experienced severe trauma including torture, witnessing the death of family members, beatings, and detention[1] (Porter & Haslam, 2005; Steel et al., 2009). Some refugees have spent years in refugee camps prior to resettlement where stressors like lack of resources to meet basic needs and continued safety concerns can contribute to elevated levels of distress (Rasmussen, et al. 2010).

As a result of these traumatic experiences, refugees are at increased risk of post-traumatic stress symptoms, anxiety and depression. Refugees are ten times more likely to have PTSD than native-born populations in resettlement countries (Porter & Haslam, 2005). Refugees who have experienced prolonged exposure to multiple traumas are at increased risk of developing acute or chronic PTSD symptoms (Cortois, 2008; Silove, 1999).

When resettling in the United States, refugees face multiple barriers to stability including lack of employable skills, language difficulties and cultural adjustment difficulties (Morris, Popper, Rodwell, Brodine, Brower, 2009). These resettlement stressors can be compounded by untreated trauma-related mental distress (Silove, 1999). Multiple federal, state, and private non-profit social service agencies provide resettlement services to refugees after arrival in the United States to mitigate some of these difficulties. However, due to a lack of culturally relevant assessment and treatment models, among other barriers, mental health services for refugees in the United States are lacking (Hollifield, et al, 2002).

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[1] For resettlement purposes, the United Nations defines a refugee as someone who is outside his or her country of nationality and is "...unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion..." (USCIS, 2008)

The federal Refugee Act of 1980 entitles resettling refugees to a comprehensive health assessment and referral to appropriate health services soon after arrival in the US. Most states receive federal dollars through the Office of Refugee Resettlement to fund a Refugee Health Coordinator to coordinate state-wide health programs for refugees. While there are recommendations from the Office of Refugee Resettlement that offer guidance for developing health screenings, the content and scope of screenings varies from state to state. While some states offer no mental health screening at all, other states, like Colorado, have comprehensive refugee mental health assessment and referral structures (Savin, Seymour, Littleford, Bettridge, Giese, 2005).

Scope of the Project

The Refugee Mental Health project is a large-scale, multi-phased research project that is a partnership between the University of Minnesota School of Social Work, the University of Minnesota Department of Family Social Science, the Center for Victims of Torture, and the Minnesota Department of Public Health Refugee Health Coordinator's Office. To address the dearth of culturally relevant and validated mental health screening tools for use with refugees, the research team is developing and validating a brief mental health screening tool that assesses for potential depression, anxiety and PTSD among refugees resettling in the United States. To begin this process, the research team conducted focus groups with refugees and community leaders in four ethnic communities in the Twin Cities including the Somali, the Oromo, the Karen and the Bhutanese. Information from this focus group and follow-up interviews with ethnic leaders was used to develop an 18-item brief mental health screening tool. The research team will adapt this tool to make it accessible for use in public health clinics,

community-based non-profit agencies and in ethnic community based organizations. The research team will develop and cultivate culturally grounded and appropriate referral and treatment options for refugees with identified mental health needs, including service providers from within the ethnic communities. The research team will evaluate potential new models of treatment for refugees including Narrative Exposure Therapy and Parent Management Training – Oregon Model (PMTO).

Summary of Activities

During June, July and August of 2009 I was supported by a CURA grant to work as a research assistant with the Refugee Mental Health project. During this time I accomplished the following tasks:

1. I worked with the research team to develop an interview guide for the focus groups. Interview questions focused on cultural expressions of mental and emotional distress related to war trauma and views about what helps and what doesn't help with addressing these issues.
2. I worked with cultural leaders in four ethnic communities to recruit participants for 12 focus groups.
3. I co-facilitated the 12 focus groups with the research team.
4. I transcribed audio-recordings of many of the focus groups.

Since the end of my CURA grant I have continued to work with the Refugee Mental Health project as a Graduate Research Assistant. In September 2010 I began my third year in the

Social Work doctoral program and in March 2010 I will begin my dissertation which will utilize data collected with the Refugee Mental Health Project.

Progress to Date

To date the Refugee Mental Health project has accomplished the following objectives.

1. Research staff have conducted 12 focus groups with men, women, and youth ages 18 to 25 from four ethnic communities.
2. Data from these focus groups has been analyzed using a method adapted from grounded theory (Glaser & Strauss, 1967).
3. A brief screening tool specific to the Karen community has been developed and tools for the other ethnic groups are being developed.
4. Preparations are being made to pilot test the Karen screening tool at HealthEast Roselawn Clinic in St. Paul.
5. A psycho-educational curriculum successful at Center for Victims of Torture has been adapted for the Karen community and will be evaluated in practice during winter 2010.
6. A nation-wide survey of refugee mental health screening practices at the state level was conducted, the data has been analyzed and a resulting paper has been submitted for publication with the American Journal of Public Health.
7. Data and findings from the initial phases of the Refugee Mental Health project have been presented at multiple conferences and have been accepted for presentation at the International Society for Traumatic Stress Studies conference in November, 2010 and at the Society for Social Work Research in January, 2011.

Policy Recommendations

Results of this multi-faceted study illuminate three recommendations for policy changes at the state and national level and recommendations for further research.

1. **There is a need for training in recognizing culturally-bound symptoms of war- and resettlement-related mental distress at all levels.** Our research indicates that ethnic-led community based organizations desire training around understanding and recognizing war-related mental and emotional distress. Conversely, mainstream organizations indicate a desire for training around the cultural and political context of trauma. Training state-level Refugee Health Coordinators to recognizing mental health symptoms in refugees may encourage implementation of screening practices.
2. **Guidelines for practice in screening are helpful, but policies mandating or funding screening at the state level would encourage more uniform screening practices.** Data collected during focus groups as well as from the national survey of state-level practices in refugee mental health screening indicated there is little uniformity in the ways that states address refugee mental health issues. Some states have comprehensive screening and treatment programs while others do not address refugee mental health at all. Public health practitioners and state Refugee Health Coordinators report a lack of mandate as one reason for not screening refugees for mental health issues. Additionally, states report a lack of a culturally viable or relevant screening tool for use with refuges as a barrier to screening.
3. **Further development and support of culturally adapted and grounded treatment for refugees is also needed.** Even when states provide comprehensive screening there is a

dearth of culturally relevant or grounded treatment programs for refugees. Interventions and treatment groups must be adapted to fit refugees' cultural and emotional needs. Training for front-line service providers including public health clinic staff, voluntary resettlement agency workers, mainstream social service providers and ethnic led community based organizations in recognizing is essential.

Additionally, our research findings highlight the importance of addressing family systems in treatment. Trauma takes place within a family context and exposure to war trauma can increase vulnerability to domestic violence and substance abuse. There are few culturally grounded treatment programs for domestic violence or substance abuse. Mental health treatment programs that do work with refugees tend to focus on one area like PTSD or depression. More holistic treatment programs that address multiple components of family systems are needed.

4. **There is a need for continued research in these areas.** In addition to policy recommendations, this study has consistently highlighted the continued need for research in this area. In particular there is a continued need to develop and test evidence-based, culturally grounded interventions that address war- and resettlement-related PTSD, anxiety and depression in refugees. Second, there is a continued need to better understand culturally grounded mental and emotional responses to both war trauma and the resettlement experience. Many refugees in this study reported that PTSD, anxiety and depression symptoms related to war-trauma are compounded by resettlement stressors. Further research to better described interrelated and compound stressors could help with developing better, more targeted interventions.

References

Cortois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice and Policy, S*(1), 86-100.

Glaser B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishing Company.

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkinds, J. H., Kesler, J., Stevenson, J., Westermeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *Journal of the American Medical Association, 288*(5), 611-621.

Morris, M., Popper, S., Rodwell, T., Brodine, S., & Brouwer, K. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health, 34*(6), 529-538.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical Association, 294*(5), 602.

Rasmussen, A., Nguyen, L., Wilkinson, J., Vundla, S., Raghavan, S., & Miller, K. (2010). Rates and impact of trauma and current stressors among Darfuri refugees in Eastern Chad. *American Journal of Orthopsychiatry, 80*(2), 227-236.

Savin, D., Seymour, D. J., Littleford, L. N., Bettridge, J., & Giese, A. (2005). Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Reports, 120*, 224-229.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations and refugee trauma: Toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4), 200-207.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *Journal of the American Medical Association, 302*(5), 537-549.

United States Citizenship and Immigration Services. (2008). *Definition of a refugee from the immigration and nationality act.* Retrieved from http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=091a96981298d010VgnVCM10000048f3d6a1RCRD

Vergara, A. E., Miller, J. M., Martin, D. R., & Cookson, S. T. (2003). A survey of refugee health assessments in the United States. *Journal of Immigrant Health, 5*(2), 67-73.